State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
BOARD OF PODIATRIC MEDICINE
1420 HOWE AVENUE, SUITE 8, SACRAMENTO, CA 95825-3229
PHONE: (916) 263-2647 FAX: (916) 263-2651
CALNET: 8-435-2647 TDD: (916) 322-1700

www.dca.ca.gov/bpm

CERTIFICATE OF APPROVED RESIDENCY TRAINING

This is to certify that _____,
Resident's Name
a resident of _____, participated in
Name of Program
an approved residency offered by _____
Name and Address of Sponsoring Facility
_____

from _____, _____ thru _____, _____in the residency
Date *Year* *Date* *Year*

category of _____and that the above named resident successfully
RPR, POR, PPMR, PSR-12, PSR-24 or PSR-24+

completed this residency on _____, _____.
Date *Year*

I, _____ certify that I am/was the program director for the
Type Or Print Name Of Program Director
resident named above during the residency program indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect.

_____
Signature of Program Director

_____ Phone Number: ( )_____-_____
Address (Number and Street)

_____
City, State, Zip Code

NOTE: APPROVED PODIATRIC RESIDENCIES ARE THOSE PROGRAMS THAT HAVE BEEN FULLY APPROVED BY THE COUNCIL ON PODIATRIC MEDICAL EDUCATION.

P4